



Traumatic Grief: *Cognitive, Behavioral and Somatic Approaches*

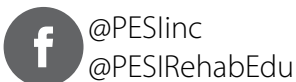
J. Eric Gentry, PhD, LMHC, DAAETS, FAAETS

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J. Eric Gentry, PhD, LMHC, DAAETS, FAAETS is an internationally recognized leader in the study and treatment of traumatic stress and compassion fatigue. His Ph.D. is from Florida State University where he studied with Professor Charles Figley—a pioneer of these two fields. In 1997, he co-developed the Accelerated Recovery Program (ARP) for Compassion Fatigue—the world’s only evidence-based treatment protocol for compassion fatigue. In 1998, he introduced the Certified Compassion Fatigue Specialist Training and Compassion Fatigue Prevention & Resiliency Training. These two trainings have demonstrated treatment effectiveness for the symptoms of compassion fatigue and he published these effects in several journals. He has trained over 100,000 health professionals over the past 20 years.

Dr. Gentry was original faculty, curriculum designer and Associate Director of the Traumatology Institute at Florida State University. In 2001, he became the co-director and moved this institute to the University of South Florida where it became the International Traumatology Institute. In 2010, he began the International Association of Trauma Professionals—a training and certification body—for which he was the vice-president.

In 2005, Hogrefe and Huber published *Trauma Practice: Tools for Stabilization and Recovery*—a critically acclaimed text on the treatment of traumatic stress for which Dr. Gentry is a co-author. The Second Edition was released in 2010 and the Third Edition in 2015. He is also the author of the groundbreaking *Forward-Facing® Trauma Therapy: Healing the Moral Wound*. He is the co-author of *Forward-Facing® Professional Resilience: Resolution and Prevention of Burnout, Toxic Stress and Compassion Fatigue, Unlocking the Keys to Human Resilience, and Transformative Care: A Trauma-Focused Approach to Caregiving*. These books provide a new vision for trauma therapy in the 21st Century. He has written numerous chapters, papers, and peer-reviewed journal articles in the areas of traumatic stress and compassion fatigue. Dr. Gentry is a Master Traumatologist with over 35 years of clinical experience with trauma, Complex PTSD, personality disorders, and dissociation.

He is the President and CEO of The Forward-Facing® Institute and owner of Compassion Unlimited-- a private psychotherapy, training, and consulting practice—in Phoenix, AZ.

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Materials that are included in this course may include interventions and modalities that are beyond the authorized practice of mental health professionals. As a licensed professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the boundaries of practice in accordance with and in compliance with your professions standards.



Traumatic Grief

Cognitive, Behavioral and Somatic Approaches

J. Eric Gentry, PhD, LMHC, FAAETS

Traumatic Grief

Cognitive, Behavioral and Somatic Approaches
...from a Salutogenic Paradigm

1

APA CEU Statement

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Effectiveness and Limitations


- The first half of this presentation is simply factual peer-reviewed research on Traumatic Grief – no risks of limitations (other than there needs to be more research into the understanding of traumatic grief)
- The second half of this presentation is on Treatment of Traumatic Grief and does come with some risks and limitations:
 - The presentation reports on two systematic reviews of treatment for Traumatic Grief. There has been minimal treatment development on this phenomenon, so mostly the presentation reports on adapting current treatment protocols to fit to address the treatment issues of Traumatic Grief.

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- The presentation explores a model developed by Smid et al., 2015 called "Brief Eclectic Psychotherapy for Trauma Grief (BEP-TG)". About the efficacy of this model the authors state: *Although BEP-TG consists of components with proven effectiveness in the treatment of PTSD, PCBD, and MDD, the efficacy of the full BEP-TG protocol in reducing symptoms of these disorders following traumatic loss remains to be established.*
- The *Family Resilience with Traumatic Grief* developed by Oscan & Kaya in 2019 reports effectiveness data with a small N.
- A *Salutogenic "Active Ingredients" Approach*, developed and utilized by the presenter—while it utilizes the four primary "active ingredients/common factors" has no effectiveness or efficacy data. This method is offered as only a method for lessening distress associated with Traumatic Grief, not resolving the symptoms.
- There is not yet enough treatment data to offer "evidence-based" treatments for the condition of Traumatic Grief

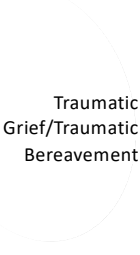
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Risks

- Anytime a clinician is working with someone suffering symptoms of Traumatic Grief (which includes symptoms of Prolonged Complex Bereavement Disorder, Posttraumatic Stress, and Major Depressive Disorder), the treatment is fraught with risks. Each of these conditions have high risk for intentional and accidental suicide, substance use/abuse, impulsivity, compulsivity with moderate to severe impairment.
- Any treatment protocol or process must constantly assess for safety, impairment, self-harm, and self-destructive methods of coping.
- Since exposure is an indicated and important element of reported effective treatment with TG, care should be taken to teach, coach, monitor and facilitate these exposure activities only with those who are able to remain in a down-regulated ANS to minimize the possibility of abreaction and retraumatization.

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Traumatic Grief/Traumatic Bereavement

- Traumatic Grief [Traumatic Bereavement] usually involves the unexpected—sometimes violent or horrific—loss of a loved one.
- When people lose intimates unexpectedly, from malicious acts of violence, they are at risk for chronic grief reaction.
- Traumatic Grief is an alchemy of Persistent Complex Bereavement Disorder [PCBD] and Posttraumatic Stress Disorder [PTSD].
- *In the universe of life events, traumatic loss and traumatic stress intersect a great deal, both in event dimensions and psychological impact (p.73).*
- While grief and trauma frequently intersect, *grief is a distinct individual, social, and relational experience (p. 74)*

Neria & Litz (2004)
Jacobs, Mazure & Prigerson (2000) 6

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Early Developments

16% of persons who suffered loss by traumatic means met DX criteria (DSM-IV) for PTSD and 22% met lifetime PTSD criteria.

Traumatic Grief was developed from Chronic Bereavement

The diagnostic criteria for Traumatic Grief is built around two components/constructs:
Separation Distress and Traumatic Distress

traumatic grief is 18.6% in global clinical populations

Green et al., 2001
Neria & Litz, 2004
Horowitz et al., 1999
Prigerson et al., 1997;1999; 2001
Kersting et al., 2011

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Symptoms

Separation Distress

- Intrusive, distressing preoccupation with the deceased;
- Yearning, longing and pining;
- a perceptual set including visual, tactile, and auditory illusions
- Crying
- Searching for the deceased;
- Extreme loneliness

Traumatic Distress

- Feeling unfulfilled without the deceased;
- Avoidance of painful reminders of the loss;
- Futility about the future;
- Feeling [believing] a part of the self has died;
- Numbness and detachment;
- Shattered world view (regarding trust, security and control);
- Feeling shocked, stunned and dazed;
- Disbelief about the death;
- Emptiness;
- Taking on symptoms or harmful behaviors of the deceased;
- Bitterness

Traumatic Grief is associated with multiple physical health problems: High BP; cancer; cardiac events; ulcerative colitis; suicidality and global dysfunction

Prigerson & Jacobs, 2001
Neria & Litz, 2004
Prigerson et al., 1997;1999; 2001 8

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Symptoms

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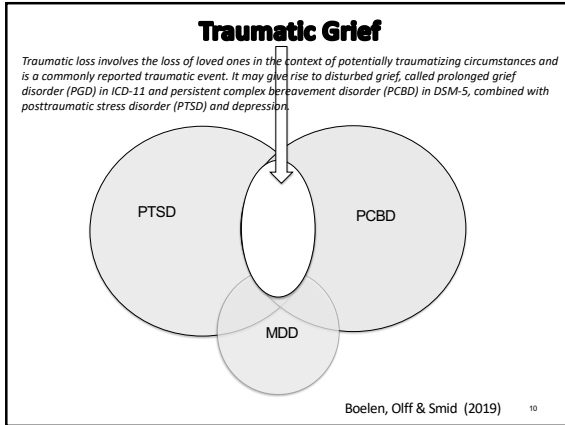
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Prigerson & Jacobs, 2001
Neria & Litz, 2004
Prigerson et al., 1997;1999; 2001 9

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- Proposed Diagnostic Criteria for Traumatic Grief**
- Criterion A**
1. The person experienced the death of a significant other.
 2. The response involves intrusive, distressing preoccupation with the deceased person (e.g., yearning, longing, or searching).
- Criterion B**
- In response to the death, the following symptom(s) is/are marked and persistent:
1. Frequent efforts to avoid reminders of the deceased (e.g., thoughts, feelings, activities, people, places)
 2. Purposelessness or feelings of futility about the future
 3. Subjective sense of numbness, detachment, or absence of emotional responsiveness
 4. Feeling stunned, dazed, or shocked
 5. Difficulty acknowledging the death (e.g., disbelief)
 6. Feeling that life is empty or meaningless
 7. Difficulty imagining a fulfilling life without the deceased
 8. Feeling part of oneself has died
 9. Shattered worldview (e.g., lost sense of security, trust, or control)
 10. Assumes symptoms or harmful behaviors of, or related to, the deceased person
 11. Excessive irritability, bitterness, or anger related to the death
- Criterion C**
- The duration of the disturbance (symptoms listed) is at least two months
- Criterion D**
- The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning
- Jacobs, S., Mazure, C. & Prigerson, H. (2000)
Bruno et al., (2019)
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- The Traumatic Grief Inventory Self-Report Version (TGI-SR):**
- I had intrusive thoughts and images associated with his/her death
 - I experienced intense emotional pain, sorrow, or pangs of grief
 - I felt a strong longing or yearning for the deceased
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 - I had trouble to accept the loss
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 - I experienced a desire to die in order to be with the deceased
 - I felt alone or detached from other people
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Boelen & Smid (2017)

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Treatment of Traumatic Grief

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**Treatment of Traumatic Grief
(Early Years)**

- In January 1997, a panel of experts in the areas of bereavement, trauma, and psychiatric nosology convened to discuss the need for diagnostic criteria for complicated grief, or what we now prefer to call *Traumatic Grief* (Prigerson et al., 1999)
- Traumatic Grief = Separation Distress + Traumatic Distress
- Resistant to interpersonal psychotherapy and tricyclic antidepressants (separation distress sx more acute and debilitating than MDD)
- Attempts to develop psychotherapeutic treatments that addressed both Separation & Traumatic Distress

Prigerson et al., (1995)
Prigerson et al., (1997a & b)
Prigerson et al., (2000) 14

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What Works?

- **Relationally-driven treatment**
[Feedback Informed Treatment]
- **Crisis Intervention**
– Stabilization & Case Management
- **Brief Dynamic Psychotherapy**
– Separation Anxiety
– Attachment wounding
- **Cognitive Behavioral Therapy**
– Perceptual distortions
– Avoidance
- **Exposure Therapy**
– Grief & Trauma both
– In vivo or imaginal
- **EMDR**
- **Brief Eclectic Psychotherapy for Traumatic Grief**

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Grieving allows us to heal,
to remember with love rather than pain.

It is a sorting process.
One by one you let go of things that are gone
And you mourn for them.
One by one you take hold of the things that have become part of
Who you are and build again.

--Rachel Naomi Remen,
in Worden, 2002

Counseling or Therapy?
GRIEF & MOURNING

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Grief Counseling & Grief Therapy
(Worden, 2018)

<p>< 1 YEAR Assume Health and Support</p> <ol style="list-style-type: none"> 1. Listen 2. Build & maintain relationships 3. Educate (validate & normalize) 4. Case Management (connect with services; help with basic needs) 5. Teach self-regulation 	<p>> 1 YEAR Helper more active</p> <ul style="list-style-type: none"> • All support functions • Facilitate narrative (eulogy) paired with relaxed body • Help create new relationship with deceased.
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Tasks of Mourning
(Worden, 2018)

1. Accept the Reality of the Loss
2. **Process the Pain of Grief**
3. Adjust to a World without the Deceased (Object)
 - a. External Adjustments
 - b. Internal Adjustments
 - c. Spiritual Adjustments
4. Find an Enduring Connection with the Deceased in the Midst of embarking on a New Life

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Active Ingredients/ Common Factors

- VA/DoD
 - Management of Post-Traumatic Stress Working Group (2010)
- ISTSS
 - Cloitre, et al. (2011)
- EU TSN
 - Schnyder, et al., (2015)
- Common Elements of Trauma Approach Johns Hopkins
 - Murray, et al., (2015)
- *Determining what works in the treatment of PTSD*
 - Benish, Imel & Wampold (2008)
 - Wampold et al., (2010)
 - Norcross, J. C., & Wampold, B. E. (2019).
- *Trauma competency: An active ingredients approach to treating posttraumatic stress disorder*
 - Gentry, Baranowsky & Rhoton (2017)

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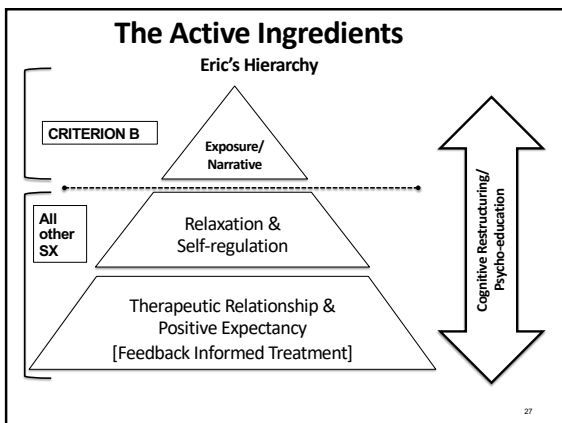
Healing Trauma: Active Ingredients

(Gentry, Baranowsky & Rhoton, 2017)

- **Therapeutic Relationship**
- **Relaxation/Self-Regulation**
- **Exposure**
- **Cognitive Restructuring/ Psychoeducation**

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DISTRESS with LOSS and GRIEF

- **Loss and Grief are perceived threats**
 - Developmental history of painful past learning with loss and the experience of grief in our bodies
- Remaining in the context of perceived threat without interrupting the physiological increase of energy and simultaneous progressive loss of neocortical functioning becomes involuntary mobilization (aggression/avoidance)
- The inability to navigate to perceived safety and/or intentionally interrupt the threat response somatically (INTEROCEPTION) or cognitively (NEUROCEPTION) will frequently result in **involuntary immobilization**
- These two outcomes explain the bipolar and biphasic nature of both PCBD and PTSD. Both with high levels of distress
- **Sustained threat response (SNS Dominance) = Distress**

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DESENSITIZATION → EXTINCTION

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- Reciprocal Inhibition
 - Sensory Experience (*in vivo* or witnessed) + PAIN/FEAR = similar sensory experiences becoming CS in the future
 - CR = FEAR/THREAT RESPONSE + TIME >>> SNS Dominance (symptoms) and Compulsive Self-defense
 - PTSD = Perception of threat in the environment and memory there is little or no danger
 - PCBD = Perception of threat in the body and memory where there is grief but no danger
 - No danger = No need for threat response
 - Interrupt threat response + confront scary environment (*in vivo* exposure), memory (imaginal exposure) and body (release involuntarily constricted muscles)
 - CS + Relaxation = Desensitization + Repeat = Extinguish Distress

***In vivo* exposure + self-regulation as triage for Traumatic Grief**
 Stabilization – Increased Functioning – Comfort – Sx Amelioration - Intentionality

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Traumagenesis

Pairing Sensory Stimulus with Threat Response =
Conditioned Stimulus

Essentially ALL trauma is associational learning

Distress in the present is the intrusion of painful sensory memories from the past that cause our bodies to go into a threat response

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Reciprocal Inhibition
(Extinction)

CS + RELAXATION =
Desensitization (extinction) of CR [ANX] + Multiple
times = EXTINCTION of CR

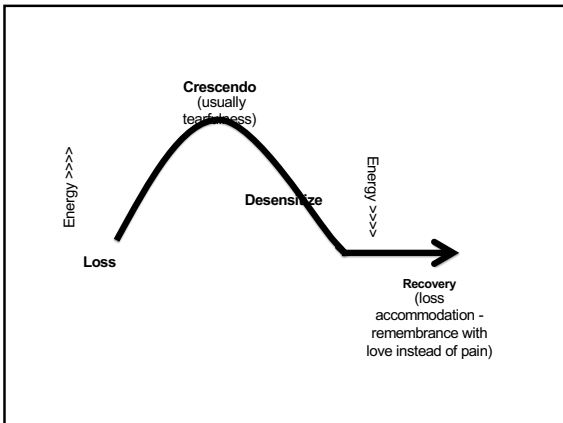
The diagram shows a sequence of 'Relax + [dog image]' pairs, followed by an equals sign and an image of a person hugging a dog.

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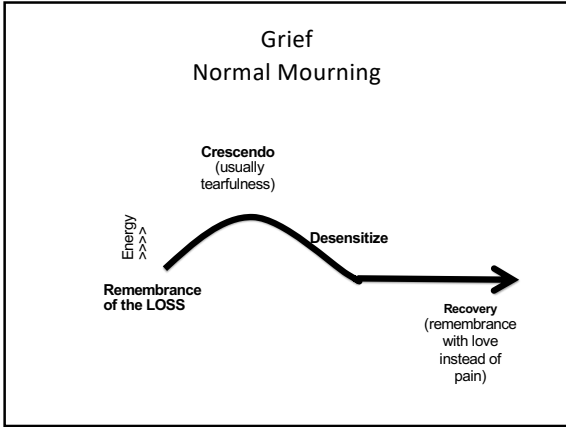
GRIEF

...wants to be integrated and desensitized
 ...is a self-healing system at work
 ...is simple to resolve

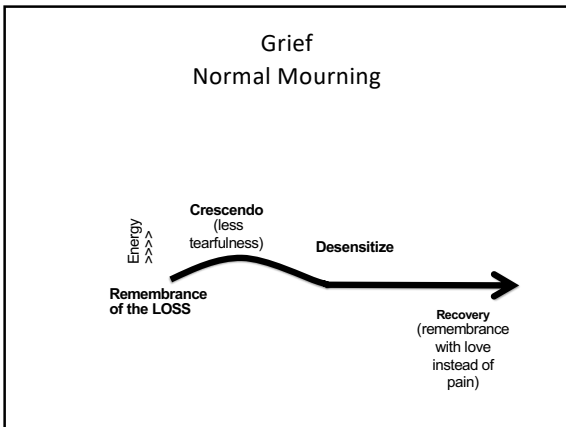
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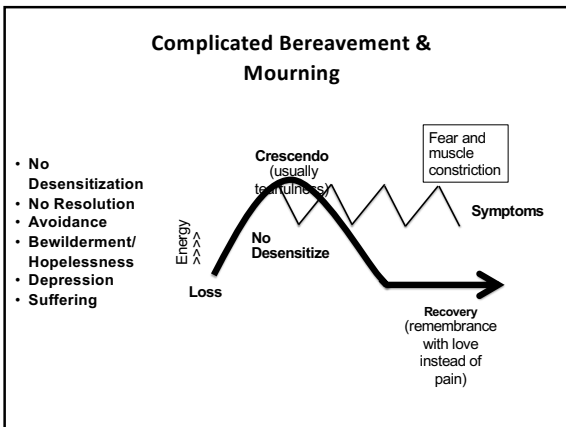
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INTEGRATION

TRAUMATIC GRIEF (Memory + Pain of Grief) is instinctually avoided by suppression, repression and/or dissociation

INTEGRATION is completed by exposure + narration of the losses; remembrance; restoration of relationship; completing any tasks that may need done to restore honor.

NARRATIVE/EULOGY is an intentional languaging of the loss and the survivors experience with the loss and the grieving process.

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PROBLEM to SOLUTION

RELAXATION

Remembrance of Loss + Relaxed Body =
Desensitization and lessening of pain

NARRATIVE

Telling Story of Loss (Eulogy)+ Relaxed Body =
Relegating Loss to the Past +
Remembering with Love (instead of Pain)

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Resolution

Re-starting and Completing Organic Grieving

Soften Muscles in Body

- Lower arousal
- Confronting pain
- Desensitizing fear
- Resolving grief

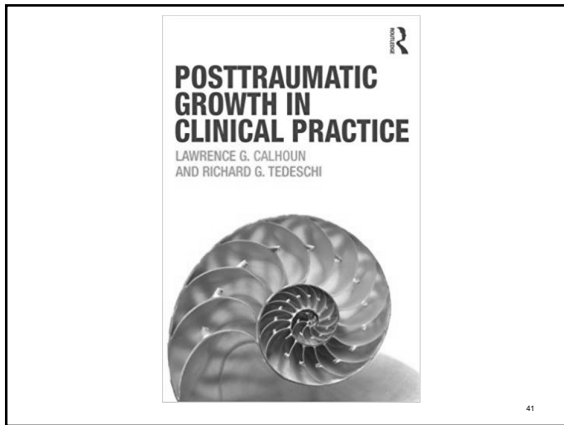
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Three Steps to Resolving Grief

- 1. Supportive Relationship** (must have people who we can turn to in our pain and who can listen without anxiety)
- 2. Relaxed Body** (regulation by softening muscles)
- 3. Telling our Story** (Narrative IS integration and relegates loss to the past allowing us to remember with love)
- 4. Posttraumatic Growth**

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POSTTRAUMATIC GROWTH

WHAT IS POSTTRAUMATIC GROWTH?

➔

It is positive change experienced as a result of the struggle with a major life crisis or a traumatic event



The greatest souls are awakened out of suffering. The most impressive personalities endure many scars.

- Tedeschi, R. G. & Calhoun, L. G. (1990). The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress*, 3(3), 455-471.
- Calhoun, L. G. & Tedeschi, R. G. (2013). *Posttraumatic growth in clinical practice*. New York: Brunner Routledge.

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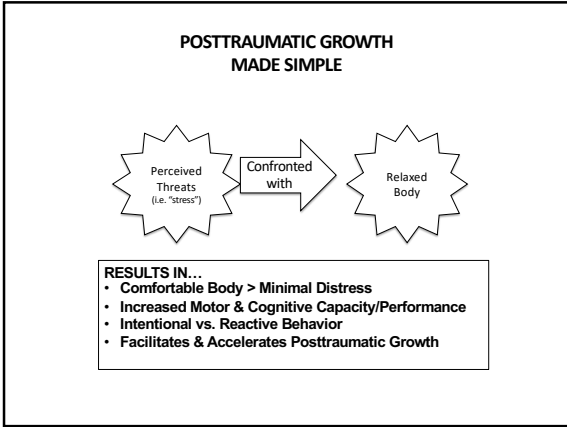
Posttraumatic Growth for Traumatic Grief
Dr. Tedeschi

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Boelen, P. A., & Smid, G. E. (2017). The traumatic grief inventory self-report version (TGI-SR): introduction and preliminary psychometric evaluation. *Journal of Loss and Trauma*, 22(3), 196-212.

Proposed Criteria for Traumatic Grief (2000)

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Criterion C

The duration of the disturbance (symptoms listed) is at least two months

Criterion D

The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning

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